REQUEST for STAKEHOLDER COMMENT
Design and Development of an Insurance Exchange in Connecticut

The following information is organized by general topic area, with a list of questions we would like you/your organization to answer as you feel appropriate. These questions are followed by background briefings to provide a general understanding of the topics. To encourage productive discussion during each meeting, we are providing you this information in advance of your meeting. While these topic areas are the specific issues for which public comment is requested, please feel free to offer any other comments on policies related to the Exchange and the insurance market as well.

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We also wish to add the following Addendums to this document:

Addendum A: Names of Connecticut Producers submitting this information and attending the meeting.

Addendum B: Other issues which we judge were not addressed in this Stakeholder Comment Survey.

Addendum C: The NAIC draft document dated March 7, 2011, The Comparative Roles of Navigators and Producers In an Exchange. We judge this is a vital part of the conversation in creating an exchange.

Addendum D: The NAIC draft document dated March 16, 2011, Adverse Selection. We judge this is a vital part of the conversation in creating an exchange.

QUESTIONS

Please provide us with your thoughts and insights on the questions listed below as you feel appropriate.

A. Establish a Responsive and Efficient Structure

1. Should Connecticut consider joining a multi-state Exchange? Under a regional Exchange, would Connecticut benefit most from a separate or merged risk pool?

No Each state has a unique marketplace for individual and small group medical insurance products.

The Exchange is not a risk pool. It is to be a web based source for information on the medical insurance options offered by participating health plans and an on line enrollment process.

2. Should Connecticut administer the Exchanges for the individual and small group markets separately or jointly? If jointly, should Connecticut maintain separate risk pools for the two Exchanges, or merge the risk pools.

The federal health reform law referred here as P PACA indicates health plans must maintain a pool of claims for their in and out of the Exchange plans. Thus, an Exchange will not have a "pool" of all participating health plans.

3. Should Connecticut open the Exchange to businesses with 2-100 employees in 2014, or should it allow businesses with 2-50 employees in 2014 and increase participation to businesses with 51-100 employees in 2016?

Best to begin with Connecticut's current small group definition.

4. Should Connecticut seek to expand access to businesses with more than 100 employees in 2017, with HHS approval?

Expanding to employers with up to 100 employees in 2016 and to larger in 2017 must be based on what success the Exchange has during the first couple years.

B. Address Adverse Selection and the External Market

1. Should Connecticut allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange?

It will be very important to have a dual market with products available outside in addition to within the Exchange. Thus, individuals and small employers will have additional options

Under a dual market scenario, what additional rules should Connecticut establish to prevent insurers from discouraging participation in the Exchange? What hybrid models might Connecticut consider, and what characteristics do they offer that would benefit Connecticut?

The Connecticut marketplace for medical insurance now offers consumers many product options and this should continue.

Consumers are best served when they have access to a variety of products to meet the needs they have in their various life and health stages. This is very important thus Health Plans should work to offer various plan options within the four product levels available in the Exchange.

The important point here is the admin load the Exchange places on participating health plans could easily make Exchange plans more expensive.

2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange?

The more complex the Exchange management and operational structure, the higher the operating cost, which will result in higher plan premiums.

3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms?

C. Simplify Health Insurance Purchase

1. What issues should Connecticut consider in establishing a Navigator program?

Navigator organizations will have individuals reaching out to their target populations to provide information about the Exchange. Many of these groups will be working with consumers who have never before received health insurance coverage. It is essential that all individuals working with a Navigator organization on out-reach, education, and enrollment have expertise in the Exchange functions and its coverage options. In order to ensure that Navigator organizations are providing creditable information to individuals and small employers on Exchange plan options and correctly facilitating enrollment in qualified health plans, Navigators should be subject to Connecticut's insurance licensure and continuing education requirements regulated by the State. Requiring licensure and continued training will ensure they are all qualified to provide guidance and accountable to consumer protection standards and the State of Connecticut.

2. What should Connecticut consider regarding the role of insurance brokers and agents?

Individuals, employers, employees, and their family members in Connecticut gain in various ways from the work professional health insurance agents and brokers do on a daily basis helping them purchase coverage or select an option in their employers health insurance plan, way to use their coverage effectively, and making sure they get the most out of their benefits. Help for example with claim issues may include interacting with providers to correct coding issues.

Employers gain insights and support designing benefit plans; explaining public and private benefit coordination issues and the interplay of existing federal and states law. Then too, problems such as billing issues that may occur once coverage is in place are solved. Employers are also helped to ensure compliance with state and federal laws, which is increasing as health reform is implemented. Then too, professional brokers often serve, especially for small businesses, a vital human resource function.

These professionals currently provide consumers with accurate information about their health coverage options and address consumers' needs quickly. This will be a natural fit into Exchange participation. In fact, state-level private purchasing pools and exchanges, which have achieved success, have elected to utilize the services of agents and brokers.

Position papers from the National Association of Insurance Commissioners and the Congressional Budget Office support the important work of professional health insurance brokers

Consequently, to be successful individuals and employers participating in the Exchange need to have the option to contact a state-licensed and independent agent/broker for assistance.

It is anticipated there will be a federal certification program for brokers to participate in the Exchange. Perhaps similar to the federal requirement to be certified for Medicare Advantage plans.

In addition, P PACA specifically establishes that health insurance agents and brokers be allowed to enroll individuals and group plans in exchange-based products and assist with subsidies for eligible individuals.(1) To improve coverage rates Connecticut should also consider offering agents and brokers financial remuneration for bringing individuals eligible for federal public programs, like Medicaid and Husky, into the coverage system through the exchange.

D. Increase Access to and Portability of High Quality Health Insurance

1. Should Connecticut allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should Connecticut establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?

The standard defined in P PACA should be followed. Additional details will be provided by the federal HHS but it is possible the plans currently in the Connecticut marketplace may have higher standards.

2. Should Connecticut consider establishing the Basic Health Program? What would the Basic Health Program offer as a tool to facilitate continuity of coverage and care.

Background: P PACA implements Medicaid (Husky A) coverage, effective Jan 1, 2014, for what is called newly eligible adults. Federal funds will pay for this coverage for three years. To be qualifying an individual's income must be from 57% of federal poverty level up to 133%. An additional 5% can be added.

P PACA also indicates the federal Health and Human Services will establish a "basic health program", which Connecticut may implement in lieu of offered them coverage through the Exchange. To qualify an individual's income must be from 133% up to 200% of FPL. Connecticut can implement this by contracting with what is called standard health plan(s). Before the basic health program can be implemented various certifications must be provided to HHS on coverage and amount of monthly premium.

Medical insurance coverage is so expensive in Connecticut thus to control the premium an individual must pay and the cost for the state only the essential benefits should be included. Federal funds will cover 95% of the subsidies the person would have been eligible for through the Exchange.

The basic health program, if offered, should not be effective until January 1, 2014 when the newly eligible Medicaid program begins.

3. How would the Basic Health Program impact other related programs in Connecticut?

4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)

The only way this can work so consumers can receive timely response and continuity and to control costs for the state is to have this completely automated.

E. Ensure Greater Accountability and Transparency

1. What information should Connecticut include for outreach to most effectively engage consumers? How should the information be presented?

Experience with consumers and facts on the uninsured indicate as many as one third of individuals eligible for Medicaid in Connecticut is not enrolled. Why? Many do not because their MD does not accept Medicaid or the available MD is some distance from their home. Some do not like the idea of being "on welfare".

The amount of personal financial data a person will have to provide in the online enrollment process will be significant. Thus, individuals should initially have access to a high level summary of these requirements.

2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?

3. What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?

F. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015?

2. How might the state's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange; and affect accountability, transparency, and cost-effectiveness?

P PACA indicates participating health plans must integrate claims between their same plans available in and out of the Exchange. Thus, there will not be savings from pooling. It is not anticipated that there will be much savings from admin simplification. Thus, imposing fees on health plan to cover the cost of operating the Exchange will result in the health plans having to charge a higher premium for the medical insurance plans, which are the same in and out of the Exchange.

3. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?

P PACA indicates the state must pay for the cost of any additional benefits. Thus, adding benefits will make insurance more expensive for consumers and more costly for Connecticut.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

1. Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?

2. Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

No. All participating health plans must meet all P PACA requirements. Individuals and small employers would not gain and would lose consumer protections if "any willing" health plan were allowed to participate.

3. Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?

No. The requirements in P PACA alone will make it difficult for employers.

4. What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?

5. What should be the role of the Exchange in premium collection and billing?

None. The Exchange role is to provide information on medical insurance options and an on line enrollment process. Assuming any other responsibilities will only increase the cost of Exchange operations and make the cost of plans more expensive.

6. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?

BACKGROUND by TOPIC AREA

The general information on each topic area below is intended for brief reference only.

A. Establish a Responsive and Efficient Structure

The ACA requires that all states establish an American Health Benefits Exchange for the individual market and a Small Business Health Options Program (SHOP Exchange) for the small group market. States may operate these independently or may combine them into a single Exchange. States may also form regional or multi-state Exchanges.

For the purpose of inclusion in the SHOP Exchange, the ACA defines small employers as an employer with 2-100 employees. However, until 2016, states may limit this definition to 2-50 employees; and after 2017 states may further expand participation in the SHOP Exchange.

B. Address Adverse Selection and the External Market

The ACA allows states to establish a "dual market" in which individual insurance may be purchased in and out of the Exchange, or to require that all health insurance plans sold on the individual market must be sold through the Exchange. States may also design "hybrid" solutions such as permitting supplemental coverage to be sold in external markets but requiring that all individual major medical coverage be sold in the Exchange.

The ACA establishes certain rules to protect against selection issues in a dual market, but does not deny states the ability to include additional requirements for insurance sold in the Exchange and an external market. State options

include but are not limited to requiring that all insurers in the Exchange offer all four tiers of coverage, standardizing benefits packages, and restricting the sale of "catastrophic" insurance plans. However at a minimum, the following rules apply:

- Plans inside and outside of an Exchange must be in the same risk pool, have the same premium rate (for those sold by the same company), and meet the same minimum benefits standards.
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre- existing conditions, medical status, or claims history.
- Premium variation based on age, geographic location, and smoking status must apply to plans sold both inside and outside the Exchange.
- Plans sold in the Exchange must have an open enrollment period and special enrollment periods to encourage participants to purchase coverage before they become sick.

The ACA requires that states establish a reinsurance program for the individual market inside and outside of the Exchange, for the first three years of Exchange operation. The NAIC will develop model legislation to carry out this provision. States must consider issues such as how to coordinate their high risk pools with this program.

C. Simplify Health Insurance Purchase

The ACA requires an Exchange to establish a "Navigator" program to conduct public education, advise individuals and small groups that enroll in the Exchange, help them enroll in health plan and access benefits, and provide referrals as needed to the health care ombudsman. The Navigator program must be established by awarding grants to a variety of groups, and must be financed through operational funds of the Exchange (not Federal funds received by the state to establish the Exchange).

With establishment of an Exchange, the existing relationship between brokers, carriers, and consumers is likely to change. The ACA leaves states flexibility to make decisions regarding these relationships, such as designating an official role for brokers within the Exchange apparatus, requiring certification, or regulating commissions.

D. Increase Access to and Portability of High Quality Health Insurance

The ACA requires that health plans that wish to participate in an Exchange (Qualified Health Plans) comply with certain requirements related to marketing, choice of providers, plan networks, and essential health benefits. Beyond this, states may establish additional requirements for plans that are offered on an Exchange.

The ACA provides states with the option of operating a Basic Health Program for individuals between 133% and 200% of the federal poverty level, in lieu of those individuals receiving premium subsidies for purchase of coverage. The benefits under the Basic Health Program must be at least equivalent to the essential health benefits and premiums may not be higher than those in the Exchanges.

With health care reform, individuals may be eligible for one of a variety of insurance options: Medicaid, CHIP, subsidized coverage through an insurance Exchange, and unsubsidized coverage through an Exchange. The ACA requires that there should be a single seamless process of applying for coverage for all of these programs – regardless of where a consumer enters the system.

E. Ensure Greater Accountability and Transparency

The ACA requires that Exchanges post information on the cost and quality of health plans. Specifically, states must develop an Internet website for standardized comparative information on plans, provide public ratings of participating Exchange plans, and use a standard format for presenting health plan options in the Exchange.

F. Self-Sustaining Financing

The ACA includes grant funding for planning and establishment of Exchanges, but beginning January 1, 2015, state Exchanges must be financially self-sustaining.

The ACA establishes a minimum essential benefit set to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of those benefits for individuals eligible for tax credits through an Exchange.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

Under federal law, the Exchange is required to perform these functions:

- Certify, recertify, and decertify qualified health benefits plans under the guidelines established by the federal Department of Health and Human Services (HHS)
- Operate a toll-free customer assistance hotline
- Maintain a website that allows customers to compare qualified health benefits plans offered by different insurance carriers
- Assign a rating to each qualified health plan under the rating system that will be established by HHS
- Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions
- Inform individuals about the existence of—and their eligibility for—public programs, including but not limited to Medicaid and Children's Health Insurance Program (CHIP)
- Certify individuals who are exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS
- Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded due to a failure on the part of a small employer to provide sufficient affordable coverage
- Provide information to employers on their employees who are not covered
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits